KAISER PERMANENTE®

PAYMENT POLICY

CODE EDITING

Scope

This policy applies to:

☑ Kaiser Permanente Health Plan of Washington	☑ Kaiser Permanente Health Plan of Washington Options, Inc.	
☑ Commercial	☑ Medicare	☐ Medicaid

Policy

Original Effective Date: 03/01/2014

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) has adopted the Best Practice Recommendations (BPR) for Claim Coding Policy and Edits: Standardization & Transparency (as outlined in Washington State Senate Bill 5346 and published through the Administration Simplification work of Washington Healthcare Forum for claims reimbursement) to result in accurate payment. Industry standard National Correct Coding Initiative (NCCI) policy and guidelines, including Correct Coding Initiative (CCI) code edits, Medicare Physician Fee Schedule Database (MPFSDB) indicators, Medically Unlikely Edits (MUE) for units, and ICD-10 guidelines are followed on both professional and outpatient facility claims.

Kaiser Permanente has code editing processes in place to assure that claims are coded based on industry standard guidelines. Kaiser Permanente may require medical records documentation to determine appropriateness of coding for services billed. Examples of coding reviews that might prompt a request for medical records documentation include codes with modifier 22, modifiers that bypass Medicare NCCI edits, "unlisted" codes, and high-level evaluation and management (E&M) codes.

Billing/Coding Guidelines

Claims should be submitted with industry-standard coding and procedures should be reported with the HCPCS/CPT/ICD-10 codes that most comprehensively describe the services performed.

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

CMS publishes guidelines for completing the CMS-1500 form when billing for services. Some field elements to note include:

- Field 17a: Include the appropriate taxonomy code for all lines of business.
- Field 17b: List the 10-position National Provider Identifier (NPI).

The National Uniform Billing Committee maintains codes required when using the CMS-1450 form. These include revenue codes, type of bill codes, condition codes, occurrence codes, and value codes. Kaiser Permanente requires that all submitted CMS-1500 and CMS-1450 claims are reported using the specific code sets as adopted by Health Insurance Portability and Accountability Act (HIPAA).

The code sets for procedures, diagnoses, and drugs are:

- Healthcare Common Procedure Coding System (HCPCS) for Ancillary Services/Procedures
- Current Procedural Terminology (CPT-4) for Physicians Procedures
- International Classification of Diseases, version 10 for Diagnosis and Hospital Inpatient Procedures
- National Drug Codes (NDC)

Refer to each specific code set for instructions in using codes appropriately. Some basic coding rules to keep in mind are:

- Use only codes that are valid for the date of service.
- Use modifiers on service lines when appropriate.
- Use appropriate modifier to procedure code combinations.
- Use appropriate type of bill frequency code when billing outpatient hospital claims
    - Frequency code 1 should be billed with all applicable charges for admit through discharge. A second bill with Frequency code 1 billed by the same provider for the same member on the same date of service will be denied.
    - Frequency codes 7 or 8 in conjunction with the appropriate claim change reason Condition Code are required to be used if provider is correcting or adding charges.
- Include the National Drug Code when billing a physician-administered drug.
- Link CPT codes to revenue codes when required.
- Follow Outpatient Code Editor (OCE) guidelines where required.
- Follow MUE guidelines for billing appropriate units for each service. Some codes also have guidelines regarding the maximum number of units which can be billed on the code.
    - **Example:** CPT 95165 follows the Allergen Immunotherapy payment policy.
- Follow all guidelines for diagnosis coding: ICD-10 as of Oct. 1, 2015. Special attention should be given to the following requirements:
    - Diagnosis codes should be coded to the highest specificity required for each code.

  - Refer to ICD-10 guidelines in determining if a diagnosis code can be billed in the primary position, secondary position or either position.
  - Each diagnosis code should point to the correct procedure code. Incorrect pointing could result in claim line denials.

- Factors Influencing Health Status and Contact with Health Services – Official Guidelines for Coding and Reporting; Chapter 21, Section 16
  - The following Z codes/categories that may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined.
    - Z00, Z01, Z02, Z03, Z04, Z33.2, Z31.81, Z31.83, Z31.84, Z34, Z38, Z39, Z40, Z42, Z51.0, Z51.1-, Z52, Z76.1, Z76.2, Z99.12
- Laterality Diagnosis Coding – Official Guidelines for Coding and Reporting; Section 1, B, 13
  - Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.
  - Diagnosis to Modifier – The diagnosis to modifier comparison assesses the lateral diagnosis associated to the claim line to determine if the procedure modifier matches the lateral diagnosis.
- A Professional Component will not be reimbursed when a diagnostic laboratory service is provided either manually or with automated equipment, as these codes are not subject to the Professional Component/Technical Component (PC/TC) concept or are Technical Component only codes. Kaiser Permanente follows CMS's PC/TC indicators in determining which services do not qualify for Professional Component reimbursement:
  - • CMS PC/TC Indicator 3 (Technical Component Only Codes)
  - • CMS PC/TC Indicator 9 (PC/TC Concept Not Applicable)

For laboratory/pathology claims, the requesting physician must supply the initial diagnosis. For lab services interpreted by a physician/pathologist, the physician/pathologist is responsible for correcting that diagnosis, if necessary, when the final results of the test are available. The final diagnosis should be billed on the claim.

Policy Definitions

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

Prerequisite(s)

Not applicable

References

Adjusting or canceling a claim - CGS

Best Practice Recommendation for Claim Coding Policy and Edits: Standardization & Transparency, Washington Healthcare Forum Operated by OneHealthPort

Claim change Reason (Condition Codes) - CGS

Medically Unlikely Edits (MUEs), Centers for Medicare & Medicaid Services

Medicare Claims Processing Manual: Chapter 23 – Fee Schedule Administration and Coding Requirements

Medicare Claims Processing Manual: Chapter 25 – Completing and Processing the Form CMS-1450 Data Set (PDF)

Medicare Claims Processing Manual: Chapter 26 – Completing and Processing the Form CMS-1500 Data Set. (PDF)

National Correct Coding Initiative Edits, Centers for Medicare & Medicaid Services

New Clinical edits for facility claims going into effect on Sept. 15, 2022 – Priority Health

Allergen Immunotherapy payment policy

ICD-10-CM Official Guidelines for Coding and Reporting

Modifiers – KPWA Payment policy

Frequently Asked Questions

Q1: Why is my E&M code receiving a denial as a bundled service?

A1: The E&M code has a bundled relationship with other codes billed on the same date of service. Check the codes billed against the NCCI column 1/column 2 of the correct coding edits table to verify.

The column 1/column 2 correct coding edits table contains two types of code pair edits. One type contains code pairs that should not be billed together where one code is assigned as the column 1 code and the code is assigned as the column 2 code. The other type contains a column 2 (component) code which is an integral part of the column 1 (comprehensive) code. If clinical circumstances justify allowing a CCI associated modifier, the modifier should be appended to the column 2 code of the code pair.

Q2: Why is my E&M code on my claim denied when billed with a surgical procedure?

A2: The modifier may not have been billed appropriately. All procedures are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM in the MPFSDB. If an E&M is billed on the same day as a minor surgical procedure (000 or 010) or on a major surgical procedure (090), the E&M service may be separately reportable under certain circumstances.

Usually, the decision to perform a minor surgical procedure is included in the payment for the procedure. However, if an E&M service unrelated to the decision to perform the minor surgical procedure is performed, the E&M service can be separately reported with modifier 25. If the E&M service was a decision to perform a major surgical procedure, the E&M is separately reportable with modifier 57.

Q3: Why is an NCCI Column 2 procedure not being reimbursed when an NCCI associated modifier is billed?

A3: The NCCI edits have an assigned modifier indicator. The modifier indicator "0" indicates that an NCCI modifier can't be used to bypass the edit. The modifier indicator "1" indicates that an NCCI modifier may be used to bypass the edit under appropriate circumstances. In general, these circumstances relate to separate patient encounters, separate anatomic sites, or separate specimens.

Q4: Will Kaiser Permanente review medical records for modifier 59?

A4: Yes. Kaiser Permanente reviews modifier 59 to ensure that it is appropriately being applied to procedures/services. Modifier 59 is appended to procedures/services that are not normally reported together and is often used incorrectly. It may be necessary to review the medical record to determine appropriateness.

There are circumstances when a procedure or service was distinct or independent from the other services performed on the same day. Modifier 59 may indicate that the procedure/service represents a different patient encounter, different site, separate incision/excision, or separate injury. However, when another established modifier is available, modifier 59 should not be used.

Q5: Why is my corrected facility claim being denied?

A5: A claim change reason code must be submitted when adjusting or cancelling a claim. The claim change reason codes are used to describe the specific reason for adjusting or cancelling the claim.

Revision History

01/02/2024 – Added ICD-10 under Billing/Coding guidelines

09/21/2023 – Added "modifiers that bypass Medicare NCCI edits" under Policy

04/19/2023 – Added condition code resources, type of bill code information

04/10/2023 – Removed ICD-9 references and added bullets regarding using appropriate modifiers

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08/30/2022 – Added professional/technical component (PC/TC) language for lab codes

02/01/2022 – Added language for POD and Laterality diagnosis coding

07/15/2021 – Provided example of MUE guidelines for billing appropriate units for service.

Note: This information is intended to serve only as a general reference resource regarding reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to our enrollees as legislative mandates, the provider contracts, the enrollee's benefit coverage documents, and the Provider Manual all may supplement or in some cases supersede this policy. This policy may be modified from time to time by publishing a new version of the policy on Kaiser Permanente provider website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.